

payment as provided in the compromise agreement will have the effect of reinstating the full amount of the original claim, less any amounts paid prior to default.

(iii) Effect of compromise, waiver, suspension or termination of collection action. Pursuant to the Internal Revenue Code, 26 U.S.C. 6050P, compromises and terminations of undisputed debts totaling \$600 or more for the year will be reported to the Internal Revenue Service in the manner prescribed. Amounts, other than those discharged in bankruptcy, will be included in the debtor's gross income for that year. Any action taken under paragraph (g) of this section regarding the compromise of a federal claim, or waiver or suspension or termination of collection action on a federal claim is not an initial determination for the purposes of the appeal procedures in § 199.10.

(h) *Referrals for collection*—(1) *Prompt referral*. Federal claims of \$2,500, exclusive of interest, penalties and administrative costs, or such other amount as the Attorney General shall from time to time prescribe on which collection action has been taken under the provisions of this section which cannot be collected or compromised or on which collection action cannot be suspended or terminated as provided herein, will be promptly referred to the Department of Justice for litigation in accordance with 31 CFR part 904. Such referrals shall be made as early as possible consistent with aggressive collection action made by TRICARE contractors and TMA. Referral will be made with sufficient time to bring timely suit against the debtor. Referral shall be made by submission of a completed Claims Collection Litigation Report (CCLR), accompanied by a signed Certificate of Indebtedness. Claims of less than the minimum amount shall not be referred unless litigation to collect such smaller claims is important to ensure compliance with TRICARE's policies or programs; the claim is being referred solely for the purpose of securing a judgment against the debtor, which will be filed as a lien against the debtor's property pursuant to 28 U.S.C. 3201 and returned to the referring office for enforcement; or the debtor has the

clear ability to pay the claim and the Government effectively can enforce payment, with due regard for the exemptions available to the debtor under state and Federal law and judicial remedies available to the Government.

(2) *Preservation of evidence*. The Director, TMA, or a designee will take such action as is necessary to ensure that all files, records and exhibits on claims referred, hereunder, are properly preserved.

(i) *Claims involving indication of fraud, filing of false claims or misrepresentation*. Any case in which there is an indication of fraud, the filing of a false claim or misrepresentation on the part of the debtor or any party having an interest in the claim, shall be promptly referred to the Director, TMA, or designee. The Director, TMA, or a designee, will investigate and evaluate the case and either refer the case to an appropriate investigative law enforcement agency or return the claim for other appropriate administrative action, including collection action under this section. Payment on all TRICARE beneficiary or provider claims in which fraud, filing false claims or misrepresentation is suspected will be suspended until the Director, TMA, or designee, authorizes payment or denial of the claims. Collection action on all claims in which a suspicion of fraud, misrepresentation or filing false claims arises, will be suspended pending referral to the appropriate law enforcement agencies by the Director, TMA, or a designee. Only the Department of Justice has authority to compromise, suspend or terminate collection of such debts.

(ii) [Reserved]

[73 FR 71547, Nov. 25, 2008, as amended at 77 FR 38176, June 27, 2012]

§ 199.12 Third party recoveries.

(a) *General*. This section deals with the right of the United States to recover from third-parties the costs of medical care furnished to or paid on behalf of TRICARE beneficiaries. These third-parties may be individuals or entities that are liable for tort damages to the injured TRICARE beneficiary or a liability insurance carrier covering the individual or entity. These third-parties may also include other entities who are primarily responsible to pay

for the medical care provided to the injured beneficiary by reason of an insurance policy, workers' compensation program or other source of primary payment.

Authority—(1) *Third-party payers*. This part implements the provisions of 10 U.S.C. 1095b which, in general, allow the Secretary of Defense to authorize certain TRICARE claims to be paid, even though a third-party payer may be primary payer, with authority to collect from the third-party payer the TRICARE costs incurred on behalf of the beneficiary. (See § 199.2 for definition of "third-party payer.") Therefore, 10 U.S.C. 1095b establishes the statutory obligation of third-party payers to reimburse the United States the costs incurred on behalf of TRICARE beneficiaries who are also covered by the third-party payer's plan.

(2) *Federal Medical Care Recovery Act*—(i) *In general*. In many cases covered by this section, the United States has a right to collect under both 10 U.S.C. 1095b and the Federal Medical Care Recovery Act (FMCRA), Public Law 87–693 (42 U.S.C. 2651 *et. seq.*). In such cases, the authority is concurrent and the United States may pursue collection under both statutory authorities.

(ii) *Cases involving tort liability*. In cases in which the right of the United States to collect from an automobile liability insurance carrier is premised on establishing some tort liability on some third person, matters regarding the determination of such tort liability shall be governed by the same substantive standards as would be applied under the FMCRA including reliance on state law for determinations regarding tort liability. In addition, the provisions of 28 CFR part 43 (Department of Justice regulations pertaining to the FMCRA) shall apply to claims made under the concurrent authority of the FMCRA and 10 U.S.C. 1095b. All other matters and procedures concerning the right of the United States to collect shall, if a claim is made under the concurrent authority of the FMCRA and this section, be governed by 10 U.S.C. 1095b and this part.

(c) *Appealability*. This section describes the procedures to be followed in the assertion and collection of third-

party recovery claims in favor of the United States arising from the operation of TRICARE. Actions taken under this section are not initial determinations for the purpose of the appeal procedures of § 199.10 of this part. However, the proper exercise of the right to appeal benefit or provider status determinations under the procedures set forth in § 199.10 may affect the processing of federal claims arising under this section. Those appeal procedures afford a TRICARE beneficiary or participating provider an opportunity for administrative appellate review in cases in which benefits have been denied and in which there is a significant factual dispute. For example, a TRICARE contractor may deny payment for services that are determined to be excluded as TRICARE benefits because they are found to be not medically necessary. In that event the TRICARE contractor will offer an administrative appeal as provided in § 199.10 of this part on the medical necessity issue raised by the adverse benefit determination. If the care in question results from an accidental injury and if the appeal results in a reversal of the initial determination to deny the benefit, a third-party recovery claim may arise as a result of the appeal decision to pay the benefit. However, in no case is the decision to initiate such a claim itself appealable under § 199.10.

(d) *Statutory obligation of third-party payer to pay*—(1) *Basic Rule*. Pursuant to 10 U.S.C. 1095b, when the Secretary of Defense authorizes certain TRICARE claims to be paid, even though a third-party payer may be primary payer (as specified under § 199.8(c)(2)), the right to collect from a third-party payer the TRICARE costs incurred on behalf of the beneficiary is the same as exists for the United States to collect from third-party payers the cost of care provided by a facility of the uniformed services under 10 U.S.C. 1095 and part 220 of this title. Therefore the obligation of a third-party payer to pay is to the same extent that the beneficiary would be eligible to receive reimbursement or indemnification from the third-party payer if the beneficiary were to incur the costs on the beneficiary's own behalf.

(2) *Application of cost shares.* If the third-party payer's plan includes a requirement for a deductible or copayment by the beneficiary of the plan, then the amount the United States may collect from the third-party payer is the cost of care incurred on behalf of the beneficiary less the appropriate deductible or copayment amount.

(3) *Claim from the United States exclusive.* The only way for a third-party payer to satisfy its obligation under 10 U.S.C. 1095b is to pay the United States or authorized representative of the United States. Payment by a third-party payer to the beneficiary does not satisfy 10 U.S.C. 1095b.

(4) *Assignment of benefits not necessary.* The obligation of the third-party to pay is not dependent upon the beneficiary executing an assignment of benefits to the United States.

(e) *Exclusions impermissible—(1) Statutory requirement.* With the same right to collect from third-party payers as exists under 10 U.S.C. 1095(b), no provision of any third-party payer's plan having the effect of excluding from coverage or limiting payment for certain care if that care is provided or paid by the United States shall operate to prevent collection by the United States.

(2) *Regulatory application.* No provision of any third-party payer's plan or program purporting to have the effect of excluding or limiting payment for certain care that would not be given such effect under the standards established in part 220 of this title to implement 10 U.S.C. 1095 shall operate to exclude or limit payment under 10 U.S.C. 1095b or this section.

(f) *Records available.* When requested, TRICARE contractors or other representatives of the United States shall make available to representatives of any third-party payer from which the United States seeks payment under 10 U.S.C. 1095b, for inspection and review, appropriate health care records (or copies of such records) of individuals for whose care payment is sought. Appropriate records which will be made available are records which document that the TRICARE costs incurred on behalf of beneficiaries which are the subject of the claims for payment under 10 U.S.C. 1095b were incurred as

claimed and the health care service were provided in a manner consistent with permissible terms and conditions of the third-party payer's plan. This is the sole purpose for which patient care records will be made available. Records not needed for this purpose will not be made available.

(g) *Remedies.* Pursuant to 10 U.S.C. 1095b, when the Director, TRICARE Management Activity, or a designee, authorizes certain TRICARE claims to be paid, even though a third-party payer may be primary payer, the right to collect from a third-party payer the TRICARE costs incurred on behalf of the beneficiary is the same as exists for the United States to collect from third-party payers the cost of care provided by a facility of the uniformed services under 10 U.S.C. 1095.

(1) This includes the authority under 10 U.S.C. 1095(e)(1) for the United States to institute and prosecute legal proceedings against a third-party payer to enforce a right of the United States under 10 U.S.C. 1095b and this section.

(2) This also includes the authority under 10 U.S.C. 1095(e)(2) for an authorized representative of the United States to compromise, settle or waive a claim of the United States under 10 U.S.C. 1095b and this section.

(3) The authorities provided by the Federal Claims Collection Act of 1966, as amended (31 U.S.C. 3701 *et. seq.*) and any implementing regulations (including § 199.11) regarding collection of indebtedness due the United States shall also be available to effect collections pursuant to 10 U.S.C. 1095b and this section.

(h) *Obligations of beneficiaries.* To insure the expeditious and efficient processing of third-party payer claims, any person furnished care and treatment under TRICARE, his or her guardian, personal representative, counsel, estate, dependents or survivors shall be required:

(1) To provide information regarding coverage by a third-party payer plan and/or the circumstances surrounding an injury to the patient as a conditional precedent of the processing of a TRICARE claim involving possible third-party payer coverage.

(2) To furnish such additional information as may be requested concerning

the circumstances giving rise to the injury or disease for which care and treatment are being given and concerning any action instituted or to be instituted by or against a third person; and,

(3) To cooperate in the prosecution of all claims and actions by the United States against such third person.

(i) *Responsibility for recovery.* The Director, TRICARE Management Activity, or a designee, is responsible for insuring that TRICARE claims arising under 10 U.S.C. 1095b and this section (including claims involving the FMCRA) are properly referred to and coordinated with designated claims authorities of the uniformed services who shall assert and recover TRICARE costs incurred on behalf of beneficiaries. Generally, claims arising under this section will be processed as follows:

(1) *Identification and referral.* In most cases where civilian providers provide medical care and payment for such care has been by a TRICARE contractor, initial identification of potential third-party payers will be by the TRICARE contractor. In such cases, the TRICARE contractor is responsible for conducting a preliminary investigation and referring the case to designated appropriate claims authorities of the Uniformed Services.

(2) *Processing TRICARE claims.* When the TRICARE contractor initially identifies a claim as involving a potential third-party payer, it shall request additional information concerning the circumstances of the injury or disease and/or the identify of any potential third-party payer from the beneficiary or other responsible party unless adequate information is submitted with the claim. The TRICARE claim will be suspended and no payment issued pending receipt of the requested information. If the requested information is not received, the claim will be denied. A TRICARE beneficiary may expedite the processing of his or her TRICARE claim by submitting appropriate information with the first claim for treatment of an accidental injury. Third-party payer information normally is required only once concerning any single accidental injury on episode of care. Once the third-party payer infor-

mation pertaining to a single incident or episode of care is received, subsequent claims associated with the same incident or episode of care may be processed to payment in the usual manner. If, however, the requested third-party payer information is not received, subsequent claims involving the same incident or episode of care will be suspended or denied as stated above.

(3) *Ascertaining total potential liability.* It is essential that the appropriate claims responsible for asserting the claim against the third-party payer receive from the TRICARE contractor a report of all amounts expended by the United States for care resulting from the incident upon which potential liability in the third party is based (including amounts paid by TRICARE for both inpatient and outpatient care). Prior to assertion and final settlement of a claim, it will be necessary for the responsible claims authority to secure from the TRICARE contractor updated information to insure that all amounts expended under TRICARE are included in the government's claim. It is equally important that information on future medical payments be obtained through the investigative process and included as a part of the government's claim. No TRICARE-related claim will be settled, compromised or waived without full consideration being given to the possible future medical payment aspects of the individual case.

(j) *Reporting requirements.* Pursuant to 10 U.S.C. 1079a, all refunds and other amounts collected in the administration of TRICARE shall be credited to the appropriation available for that program for the fiscal year in which the refund or amount is collected. Therefore, the Department of Defense requires an annual report stating the number and dollar amount of claims asserted against, and the number and dollar amount of recoveries from third-party payers (including FMCRA recoveries) arising from the operation of the TRICARE. To facilitate the preparation of this report and to maintain program integrity, the following reporting requirements are established:

(1) *TRICARE contractors.* Each TRICARE contractor shall submit on or before January 31 of each year an

annual report to the Director, TRICARE Management Activity, or a designee, covering the 12 months of the previous calendar year. This report shall contain, as a minimum, the number and total dollar of cases of potential third-party payer/FMCRA liability referred to uniformed services claims authorities for further investigation and collection. These figures are to be itemized by the states and uniformed services to which the cases are referred.

(2) *Uniformed Services.* Each uniformed service will submit to the Director, TRICARE Management Activity, or designee, an annual report covering the 12 calendar months of the previous year, setting forth, as a minimum, the number and total dollar amount of cases involving TRICARE payments received from TRICARE contractors, the number and dollar amount of cases involving TRICARE payments received from other sources, and the number and dollar amount of claims actually asserted against, and the dollar amount of recoveries from, third-payment payers or under the FMCRA. The report, itemized by state and foreign claims jurisdictions, shall be provided no later than February 28 of each year.

(3) *Implementation of the reporting requirements.* The Director, TRICARE Management Activity, or a designee shall issue guidance for implementation of the reporting requirements prescribed by this section.

[68 FR 6619, Feb. 10, 2003]

§ 199.13 TRICARE Dental Program.

(a) *General provisions—(1) Purpose.* This section prescribes guidelines and policies for the delivery and administration of the TRICARE Dental Program (TDP) of the Uniformed Services of the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the Commissioned Corps of the U.S. Public Health Service (USPHS) and the National Oceanic and Atmospheric Administration (NOAA) Corps. The TDP is a premium based indemnity dental insurance coverage plan that is available to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven (7) Uniformed Services

and their voluntary decision to accept enrollment in the plan and cost share (when applicable) with the Government in the premium cost of the benefits. The TDP is authorized by 10 U.S.C. 1076a, TRICARE dental program, and this section was previously titled the “Active Duty Dependents Dental Plan”. The TDP incorporates the former 10 U.S.C. 1076b, Selected Reserve dental insurance, and the section previously titled the “TRICARE Selected Reserve Dental Program”, § 199.21.

(2) *Applicability—(i) Geographic scope.* (A) The TDP is applicable geographically within the fifty (50) States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the U.S. Virgin Islands. These areas are collectively referred to as the “CONUS (or Continental United States) service area”.

(B) Extension of the TDP to areas outside the CONUS service area. In accordance with the authority cited in 10 U.S.C. 1076a(h), the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) may extend the TDP to areas other than those areas specified in paragraph (a)(2)(i)(A) of this section for the eligible members and eligible dependents of members of the Uniformed Services. These areas are collectively referred to as the “OCONUS (or outside the Continental United States) service area”. In extending the TDP outside the CONUS service area, the ASD(HA), or designee, is authorized to establish program elements, methods of administration and payment rates and procedures to providers that are different from those in effect for the CONUS service area to the extent the ASD(HA), or designee, determines necessary for the effective and efficient operation of the TDP. This includes provisions for preauthorization of care if the needed services are not available in a Uniformed Service overseas dental treatment facility and payment by the Department of certain cost-shares (or co-payments) and other portions of a provider’s billed charges for certain beneficiary categories. Other differences may occur based on limitations in the availability and capabilities of the Uniformed Service overseas dental treatment facility and a particular nation’s